



STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
310 GREAT CIRCLE ROAD
NASHVILLE, TENNESSEE 37243 - 1700

CHECKLIST

This check list will assist you in completing and returning the correct forms along with this document.
Enrollment Packets must include the following:

Home Health Recertification

Medicare Provider Number

— — — — —

Medicaid Provider Number

— — — — —

NPI Number

— — — — —

NPI Collection Form

Disclosure of Ownership

(2) HIPAA Agreements

No. 3 Group Application

Substitute W-9 Form

INSTRUCTIONS FOR COMPLETING DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

Completion and submission of this form is a condition of participation, certification, or recertification under any of the programs established by Titles V, XVIII, XIX, and XX, or as a condition of approval or renewal of a contractor agreement between the disclosing entity and the secretary of appropriate state agency under any of the above-titled programs, a full and accurate disclosure of ownership and financial interest is required. Failure to submit requested information may result in a refusal by the Secretary or appropriate State agency to enter into an agreement or contract with any such institution or in termination of existing agreements.

SPECIAL INSTRUCTIONS FOR TITLE XX PROVIDERS

All Title XX providers must complete Part II(a) and (b) of this form. Only those Title XX providers rendering medical, remedial, or health related homemaker services must complete Parts II and III. Title V providers must complete Parts II and III.

GENERAL INSTRUCTIONS

For definitions, procedures and requirements, refer to the appropriate Regulations:

Title V	-42CFR 51A.144
Title XVIII	-42CFR 420.200-206
Title XIX	-42CFR 455.100-106
Title XX	-42CFR 228.72-73

Please answer all questions as of the current date. If the “yes” space for any item is checked, list requested additional information under the Remarks Section on page 5, referencing the item number to be continued. If additional space is needed use an attached sheet.

Return the original to the State agency and retain a copy for your files.

This form is to be completed annually. Any substantial delay in completing the form should be reported to the State agency.

DETAILED INSTRUCTIONS

These instructions are designed to clarify certain questions on the form. Instructions are listed in question order for easy reference. No instructions have been given for questions considered self-explanatory.

IT IS ESSENTIAL THAT ALL APPLICABLE QUESTIONS BE ANSWERED ACCURATELY AND THAT ALL INFORMATION BE CURRENT.

- Item I (a) Under identifying information specify in what capacity the entity is doing business as (DBA), example, name of trade or corporation.
- (b) **For Regional Office Use Only.** If the “yes” space is checked for Item VII the Regional Office will enter the 5-digit number assigned by HCFA to chain organizations.

Item II - Self-explanatory.

Item III – List the names of all individuals and organizations having direct or indirect ownership interests, or controlling interest separately or in combination amounting to an ownership interest of 5 percent or more in the disclosing entity.

Direct ownership is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity. A disclosing entity is defined as a Medicare provider or supplier, or other entity that furnishes services or arranges for furnishing services under Medicaid or the Maternal and Child Health program, or health related services under the social services program.

Indirect ownership interest is defined as ownership interest in an entity that has direct or indirect ownership in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: if A owns 10 percent of the stock in a corporation that owns 80 percent of the stock in the disclosing entity, A's interest equates to an 8 percent indirect ownership and must be reported.

Controlling interest is defined as the operational or management of a disclosing entity which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity, (i.e., joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved to amend or change the by-laws, constitution, or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity or the sale or dissolution of that entity; the ability or authority, expressed or reserved, to control the sale of any or all of the assets, to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership control.

Item IV - VII - Changes in Provider Status

Change in provider status is defined as any change in management control. Examples of such changes would include: a change in Medical or Nursing Director, a new Administrator, contracting the operation of the facility to a management corporation, a change in the composition of the owning partnership which under the applicable State law is not considered a change in ownership, or the hiring or dismissing of any employees with 5 percent or more financial interest in the facility or in an owning corporation, or any change of ownership.

For Items IV – VII, if the “yes” space is checked, list additional information requested under Remarks. Clearly identify which item is being continued.

Item IV - (a & b) If there has been a change in ownership within the last year or if you anticipate a change, indicate the date in the appropriate space.

Item V – If the answer is yes, list the name of the management firm and employer identification number (EIN), or the name of the leasing organization. A management company is defined as any organization that operates and manages a business on behalf of the owner of that business, with the owner retaining ultimate legal responsibility for operation of the facility.

Item VI – If the answer is yes, identify which has changed (Administrator, Medical Director, or Director of Nursing) and the date the change was made. Be sure to include name of the new Administrator, Director of Nursing or Medical Director, as appropriate.

Item VII – A chain affiliate is any free-standing health care facility that is either owned, controlled or operated under lease or contract by an organization consisting of two or more free-standing health care facilities organized within or across State lines which is under the ownership or through any other device, control and direction of a common party. Chain affiliates include such facilities whether public, private, charitable or proprietary. They also include subsidiary organizations and holding corporations. Provider-based facilities, such as hospital-based home health agencies, are not considered to be chain affiliates.

Item VIII – If yes, list the actual number of beds in the facility now and the previous number.

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

I. Identifying Information

Name of Entity	D/B/A	Provider #	Telephone #
----------------	-------	------------	-------------

Street Address	City, County, State	Zip Code
----------------	---------------------	----------

II. Answer the following "Yes" or "No". If any of the questions are answered "Yes", list names and addresses of individuals or corporations under Remarks on page 5. Identify each item number to be continued

- A.** Are there any individuals or organizations having a direct or indirect ownership or control interest of 5 percent or more in the institution, organizations, or agency that have been convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by Titles XVIII, XIX, or XX?

Yes _____ No _____

- B.** Are there any directors, officers, agents, or managing employees of the institution, agency or organization who have ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, or XX?

Yes _____ No _____

- C.** Are there any individuals currently employed by the institution, agency, or organization in a managerial, accounting, auditing, or similar capacity who were employed by the institution's, organization's, or agency's fiscal intermediary or carrier within the previous 12 months?

Yes _____ No _____

- III. (a)** List names, addresses for individuals, or the EIN for organizations having direct or indirect ownership or a controlling interest in the entity. (See instructions for definition of ownership and controlling interest.) List any additional names and addresses under "Remarks" on page 5. If more than one individual is reported and any of these persons are related to each other, this must be reported under Remarks.

Name	Address	EIN
------	---------	-----

(b) Type of Entity:

☐ Sole Proprietorship
☐ Corporation
☐ Other (Specify)

☐ Partnership
☐ Unincorporated
Associations

-
- (c) If the disclosing entity is a corporation, list names, addresses of the Directors, and EIN's for corporations under Remarks.
-

Check appropriate box for each of the following questions:

- (d) Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (Example: sole proprietor, partnership or members of Board of Directors.) If "Yes", list names, addresses of individuals and provider numbers.

_____ Yes _____ No

Name	Address	Provider Number

- IV. (a) Has there been a change in ownership or control within the last year? _____ Yes _____ No

If Yes, give date: _____

- (b) Do you anticipate any change of ownership or control within the year? _____ Yes _____ No

If Yes, when? _____

- (c) Do you anticipate filing for bankruptcy within the year? _____ Yes _____ No

If Yes, when? _____

-
- V. Is this facility operated by a management company, or leased in whole or part by another organization?

_____ Yes _____ No

If Yes, give date of change in operations: _____

-
- VI. Has there been a change in Administrator, Director of Nursing or Medical Director within the last year?

_____ Yes _____ No

-
- VII. (a) Is this facility chain affiliated? (If Yes, list name, address of Corporation, and EIN)

_____ Yes _____ No

Name: _____ EIN # : _____

Address: _____

VII. (b) If the answer to Question VII.a. is “No”, was the facility ever affiliated with a chain? _____ Yes _____ No

Name: _____ EIN # : _____

Address: _____

VIII Have you increased your bed capacity by 10 percent or more or by 10 beds, whichever is greater, within the last 2 years?

If “Yes”, give year of change: _____ Current beds: _____ Prior beds: _____

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF IT’S AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY, AS APPROPRIATE.

Name of Authorized Representative (Typed):

Title:

Signature:

Date:

Remarks

HIPAA BUSINESS ASSOCIATE AGREEMENT

IN COMPLIANCE WITH PRIVACY AND SECURITY RULES

THIS HIPAA BUSINESS ASSOCIATE AGREEMENT (“Agreement”) is between **The State of Tennessee, Department of Finance and Administration, Bureau of TennCare (TennCare)**, 310 Great Circle Road, Nashville, TN 37243 (“Covered Entity”) and _____ (“Business Associate”), located at _____ including all office locations and other business locations at which Provider Business Associate data may be used or maintained. Covered Entity and Business Associate may be referred to herein individually as “Party” or collectively as “Parties.”

BACKGROUND

Covered Entity acknowledges that it is subject to the Privacy and Security Rules (45 CFR Parts 160 and 164) promulgated by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191.

If Business Associate provides services to Covered Entity pursuant to one or more contractual relationships, said Agreements are detailed below and hereinafter referred to as “Service Agreements.”

LIST OF AGREEMENTS AFFECTED BY THIS Execution Date HIPAA BUSINESS ASSOCIATE AGREEMENT

In the course of executing Service requests, Business Associate may come into contact with, use, or disclose Protected Health Information (“PHI”) (defined in Section 1 below). Said Service Agreements are hereby incorporated by reference and shall be taken and considered as a part of this document the same as if fully set out herein.

In accordance with the federal privacy and security regulations set forth at 45 C.F.R. Part 160 and Part 164, Subparts A, C, and E, which require Covered Entity to have a written memorandum with each of its internal Business Associates, the Parties wish to establish satisfactory assurances that Business Associate will appropriately safeguard PHI and, therefore, execute this Agreement.

1. DEFINITIONS

1.1 Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in 45 CFR §§ 160.103, 164.304, 164.504 and 164.501.

1.2 “Breach of the Security of the [Business Associate’s Information] System” shall mean the unauthorized acquisition, including, but not limited to, access to, use, disclosure, modification or destruction, of unencrypted computerized data that materially compromises the security, confidentiality, or integrity of personal information maintained by or on behalf of the Covered Entity under the terms of Tenn. Code Ann. § 47-18-2107 and this Agreement.

1.3 “Commercial Use” means obtaining protected health information with the intent to sell, transfer or use it for commercial, or personal gain, or malicious harm; sale to third party for consumption, resale, or processing for resale; application or conversion of data to make a profit or obtain a benefit contrary to the spirit of this Agreement, including but not limited to presentation of data or examples of data in a conference or meeting setting where the ultimate goal is to obtain or gain new business.

1.4 “Designated Record Set” shall have the meaning set out in its definition at 45 C.F.R. § 164.501.

1.5 “Electronic Protected Health Information” (ePHI) shall have the meaning set out in its definition at 45 C.F.R. § 160.103.

1.6 “Encryption” means the process using publicly known algorithms to convert plain text and other data into a form intended to protect the data from being able to be converted back to the original plain text by known technological means.

1.7 “Health Care Operations” shall have the meaning set out in its definition at 45 C.F.R. § 164.501.

1.8 “Individual” shall have the same meaning as the term “individual” in 45 CFR § 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).

1.9 “Marketing” means the act or process of promoting, selling, leasing or licensing any information or data for profit without the express written permission of Covered Entity.

1.10 “Privacy Officer” shall have the meaning as set out in its definition at 45 C.F.R. § 164.530(a)(1). The Privacy officer is the official designated by a Covered Entity or Business Associate to be responsible for compliance with HIPAA regulations.

1.11 “Privacy Rule” shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, subparts A, and E.

1.12 “Protected Health Information” shall have the same meaning as the term “protected health information” in 45 CFR § 164.501, limited to the information created or

received by Business Associate from or on behalf of Covered Entity. PHI includes information in any format, including but not limited to electronic or paper.

1.13 “Required By Law” shall have the same meaning as the term “required by law” in 45 CFR § 164.501.

1.14 “Security Incident” shall mean the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

1.15 “Security Event” shall mean an immediately reportable subset of security incidents which incident would include:

- a) a suspected penetration of Business Associate’s information system of which the Business Associate becomes aware but for which it is not able to verify within FORTY-EIGHT (48) HOURS or no more than TWO (2) BUSINESS DAYS (of the time the Business Associate became aware of the suspected incident) that enrollee PHI or other confidential TennCare data was not accessed, stolen, used, disclosed, modified, or destroyed;
- b) any indication, evidence, or other security documentation that the Business Associate’s network resources, including, but not limited to, software, network routers, firewalls, database and application servers, intrusion detection systems or other security appliances, may have been damaged, modified, taken over by proxy, or otherwise compromised, for which Business Associate cannot refute the indication within FORTY-EIGHT (48) HOURS or no more than TWO (2) BUSINESS DAYS of the time the Business Associate became aware of such indication;
- c) a breach of the security of the Business Associate’s information system(s)(see definition 1.2 above), by unauthorized acquisition, including, but not limited to, access to or use, disclosure, modification or destruction, of unencrypted computerized data and which incident materially compromises the security, confidentiality, or integrity of TennCare enrollee PHI; and/or
- d) the unauthorized acquisition, including but not limited to access to or use, disclosure, modification or destruction, of unencrypted TennCare enrollee PHI or other confidential information of the Covered Entity by an employee or authorized user of Business Associate’s system(s) which materially compromises the security, confidentiality, or integrity of TennCare enrollee PHI or other confidential information of the Covered Entity.

If data acquired (including but not limited to access to or use, disclosure, modification or destruction of such data) is in encrypted format but the decryption key which would allow the decoding of the data is also taken, the parties shall treat the acquisition as a breach for purposes of determining appropriate response.

1.16 “Security Rule” shall mean the Security Standards for the Protection of Electronic Protected Health Information” at 45 CFR Parts 160 and 164, Subparts A and C.

2. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE (Privacy Rule)

2.1 Compliance with the Privacy Rule. Business Associate agrees to fully comply with the requirements under the Privacy Rule applicable to "business associates," as that term is defined in the Privacy Rule and not use or further disclose PHI other than as permitted or required by this Agreement, the Service Agreements, or as Required By Law. In case of any conflict between this Agreement and the Service Agreements, this Agreement shall govern.

2.2 Privacy Safeguards and Policies. Business Associate agrees to use appropriate safeguards to prevent use or disclosure of PHI other than as provided for by the Service Agreement(s), this Agreement or as Required By Law. This includes the implementation of administrative, physical, and technical safeguards to reasonably and appropriately protect the Covered Entity’s PHI against any reasonably anticipated threats or hazards, utilizing the technology commercially available to the Business Associate (See also Section 3.2). The Business Associate shall maintain appropriate documentation of its compliance with the Privacy Rule, including, but not limited to, its policies, procedures, records of training and sanctions of members of its workforce.

2.3 Business Associate Contracts. Business Associate shall require any agent, including a subcontractor, to whom it provides PHI received from, maintained, created or received by Business Associate on behalf of Covered Entity, or that carries out any duties for the Business Associate involving the use, custody, disclosure, creation of, or access to PHI or other confidential TennCare information, to agree, by written contract with Business Associate, to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.

2.4 Mitigation of Harmful Effect of Violations. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.

2.5 Reporting of Violations in Use and Disclosure of PHI. Business Associate agrees to require its employees, agents, and subcontractors to promptly report to Business Associate any use or disclosure of PHI in violation of this Agreement and to report to Covered Entity any use or disclosure of the PHI not provided for by this Agreement. The Business Associate shall report such violation to Covered Entity within FORTY-EIGHT (48) HOURS or no more than TWO (2) BUSINESS DAYS of event.

2.6 Access of Individual to PHI and other Requests to Business Associate. If Business Associate receives PHI from Covered Entity in a Designated Record Set, Business Associate agrees to provide access to PHI in a Designated Record Set to Covered Entity in order to meet its requirements under 45 CFR § 164.524. If Business Associate receives

a request from an Individual for a copy of the individual's PHI, and the PHI is in the sole possession of the Business Associate, Business Associate will provide the requested copies to the individual in a timely manner. If Business Associate receives a request for PHI not in its possession and in the possession of the Covered Entity, or receives a request to exercise other individual rights as set forth in the Privacy Rule, Business Associate shall promptly forward the request to Covered Entity. Business Associate shall then assist Covered Entity as necessary in responding to the request in a timely manner. If a Business Associate provides copies of PHI to the individual, it may charge a reasonable fee for the copies as the regulations shall permit.

2.7 Requests to Covered Entity for Access to PHI. The Covered Entity shall forward to the Business Associate in a timely manner any Individual's request for access to or a copy of their PHI that shall require Business Associate's participation, after which the Business Associate shall provide access to or deliver such information as follows:

- a) The Parties understand that if either Party receives a request for access to or copies of PHI from an Individual which the Party may complete with only its own onsite information, the time for such response shall be thirty (30) days, with notification to the Covered Entity upon completion.
- b) If Covered Entity does not have the requested PHI onsite and directs Business Associate to provide access to or a copy of his/her PHI directly to the Individual, the Business associate shall have sixty (60) days from the date of the Individual's request to provide access to PHI or deliver a copy of such information to the Individual. The Business Associate shall notify the Covered Entity when it completes the response.
- c) If the Covered Entity receives a request and requires information from the Business Associate in addition to the Covered Entity's onsite information to fulfill the request, the Business Associate shall have thirty (30) days from date of Covered Entity's notice to provide access or deliver such information to the Covered Entity so that the Covered Entity may timely respond to the Individual within the sixty (60) day requirement of 45 CFR § 164.524.
- d) If the Party designated above responding to the Individual's request is unable to complete the response to the request in the time provided, that Party shall provide the Individual with a written statement of the reasons for the delay and the date by which the Party will complete its action on the request. The Party may extend the response time once for no more than thirty (30) additional days.

2.8 Individuals' Request to Amend PHI. If Business Associate receives PHI from Covered Entity in a Designated Record Set, Business Associate agrees to make any amendments to PHI in a Designated Record Set that Covered Entity directs or agrees to pursuant to 45 CFR § 164.526, regarding an Individual's request to amend PHI. The Business Associate shall make the amendment promptly in the time and manner designated by Covered Entity, but shall have thirty (30) days notice from Covered Entity to complete the amendment to the Individual's PHI and to notify the Covered Entity upon completion.

2.9 Recording of Designated Disclosures of PHI. Business Associate agrees to document disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.

2.10 Accounting for Disclosures of PHI. The Business Associate agrees to provide to Covered Entity or to an Individual, in time and manner designated by Covered Entity, information collected in accordance with this Agreement, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528. The Covered Entity shall forward the Individual's request requiring the participation of the Business Associate to the Business Associate in a timely manner, after which the Business Associate shall provide such information as follows:

- a) If Covered Entity directs Business Associate to provide accounting of disclosures of the Individual's PHI directly to the Individual, the Business Associate shall have sixty (60) days from the date of the Individual's request to provide access to or deliver such information to the Individual. The Covered Entity shall provide notice to the Business Associate in time to allow the Business Associate a minimum of thirty (30) days to timely complete the Individual's request.
- b) If the Covered Entity elects to provide the accounting to the Individual, the Business Associate shall have thirty (30) days from date of Covered Entity's notice of request to provide information for the Accounting to the Covered Entity so that the Covered Entity may timely respond to the Individual within the sixty (60) day period.
- c) If either of the Parties is unable to complete the response to the request in the times provided above, that Party shall notify the Individual with a written statement of the reasons for the delay and the date by which the Party will complete its action on the request. The Parties may extend the response time once for no more than thirty (30) additional days.
- d) The accounting of disclosures shall include at least the following information: (1) date of the disclosure; (2) name of the third party to whom the PHI was disclosed, (3) if known, the address of the third party; (4) brief description of the disclosed information; and (5) brief explanation of the purpose and basis for such disclosure.
- e) The Parties shall provide one (1) accounting in any twelve (12) months to the Individual without charge. The Parties may charge a reasonable, cost-based fee, for each subsequent request for an accounting by the same Individual if he/she is provided notice and the opportunity to modify his/her request. Such charges shall not exceed any applicable State statutes or rules.

2.11 Minimum Necessary. Business Associate agrees it must limit any use, disclosure, or request for use or disclosure of PHI to the minimum amount necessary to accomplish the intended purpose of the use, disclosure, or request in accordance with the requirements of the Privacy Rule.

2.11.1 Business Associate represents to Covered Entity that all its uses and disclosures of, or requests for, PHI shall be the minimum necessary in accordance with the Privacy Rule requirements.

2.11.2 Covered Entity may, pursuant to the Privacy Rule, reasonably rely on any requested disclosure as the minimum necessary for the stated purpose when the information is requested by Business Associate.

2.11.3 Business Associate agrees to adequately and properly maintain all PHI received from, or created or received on behalf of, Covered Entity

2.12 Privacy Compliance Review upon Request. Business Associate agrees to make its internal practices, books and records, including policies, procedures, and PHI, relating to the use and disclosure of PHI received from, created by or received by Business Associate on behalf of Covered Entity available to the Covered Entity or to the Secretary of the United States Department of Health in Human Services or the Secretary's designee, in a time and manner designated by the requester, for purposes of determining Covered Entity's or Business Associate's compliance with the Privacy Rule.

2.13 Cooperation in Privacy Compliance. Business Associate agrees to fully cooperate in good faith and to assist Covered Entity in complying with the requirements of the Privacy Rule.

3. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE (Security Rule)

3.1 Compliance with Security Rule. Business Associate agrees to fully comply with the requirements under the Security Rule applicable to "business associates," as that term is defined in the Security Rule. In case of any conflict between this Agreement and Service Agreements, this Agreement shall govern.

3.2 Security Safeguards and Policies. Business Associate agrees to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the covered entity as required by the Security Rule. This includes specifically, but is not limited to, the utilization of technology commercially available at the time to the Business Associate to protect the Covered Entity's PHI against any reasonably anticipated threats or hazards. The Business Associate understands that it has an affirmative duty to perform a regular review or assessment of security risks, conduct active risk management and supply best efforts to assure that only authorized persons and devices access its computing systems and information storage, and that only authorized transactions are allowed. The Business Associate will maintain appropriate documentation of its compliance with the Security Rule.

3.3 Security Provisions in Business Associate Contracts. Business Associate shall ensure that any agent, including a subcontractor, to whom it provides electronic PHI

received from, maintained, or created for Covered Entity or that carries out any duties for the Business Associate involving the use, custody, disclosure, creation of, or access to PHI supplied by Covered Entity, shall execute a bilateral contract (or the appropriate equivalent if the agent is a government entity) with Business Associate, incorporating the same restrictions and conditions in this Agreement with Business Associate regarding PHI.

3.4 Tennessee Consumer Notice of System Breach. Business Associate understands that the Covered Entity is an “information holder” (as may be Business Associate) under the terms of Tenn. Code Ann. § 47-18-2107, and that in the event of a breach of the Business Associate’s security system as defined by that statute and Definition 1.2 of this agreement, the Business Associate shall indemnify and hold the Covered Entity harmless for expenses and/or damages related to the breach. Such obligation shall include, but is not limited to, the mailed notification to any Tennessee resident whose personal information is reasonably believed to have been acquired by an unauthorized individual. In the event that the Business Associate discovers circumstances requiring notification of more than one thousand (1,000) persons at one time, the person shall also notify, without unreasonable delay, all consumer reporting agencies and credit bureaus that compile and maintain files on consumers on a nationwide basis, as defined by 15 U.S.C. § 1681a, of the timing, distribution and content of the notices. Substitute notice, as defined by Tenn. Code Ann. § 47-18-2107(e)(2) and (3), shall not be permitted except as approved in writing in advance by the Covered Entity. The parties agree that PHI includes data elements in addition to those included by “personal information” under Tenn. Code Ann. § 47-18-2107, and agree that Business Associate’s responsibilities under this paragraph shall include all PHI.

3.5 Reporting of Security Incidents. The Business Associate shall track all security incidents as defined by HIPAA and shall periodically report such security incidents in summary fashion as may be requested by the Covered Entity, but not less than annually within sixty (60) days of the anniversary of this Agreement. The Covered Entity shall not consider as security incidents, for the purpose of reporting, external activities (port enumeration, etc.) typically associated with the “footprinting” of a computing environment as long as such activities have only identified but not compromised the logical network perimeter, including but not limited to externally facing firewalls and web servers. The Business Associate shall reasonably use its own vulnerability assessment of damage potential and monitoring to define levels of Security Incidents and responses for Business Associate’s operations. However, the Business Associate shall expediently notify the Covered Entity’s Privacy Officer of any Security Incident which would constitute a Security Event as defined by this Agreement, including any “breach of the security of the system” under Tenn Code Ann. § 47-18-2107, within FORTY-EIGHT (48) HOURS or no more than TWO (2) BUSINESS DAYS of any unauthorized acquisition including but not limited to use, disclosure, modification, or destruction of PHI by an employee or otherwise authorized user of its system of which it becomes aware. The Business Associate shall likewise notify the Covered Entity within FORTY-EIGHT (48) HOURS or no more than TWO (2) BUSINESS DAYS of event.

3.5.1 Business Associate shall identify in writing key contact persons for administration, data processing, Marketing, Information Systems and Audit Reporting

within thirty (30) days of execution of this Agreement. Business Associate shall notify Covered Entity of any reduction of in-house staff persons during the term of this Agreement in writing within ten (10) business days.

3.6 Contact for Security Event Notice. Notification for the purposes of Sections 2.5, 3.4 and 3.5 shall be in writing made by certified mail or overnight parcel within FORTY-EIGHT (48) HOURS or no more than TWO (2) BUSINESS DAYS of the event, with supplemental notification by facsimile and/or telephone as soon as practicable, to:

Privacy Officer
Bureau of TennCare
310 Great Circle Rd.
Nashville Tennessee
Phone: (615) 507-6855
Facsimile: (615) 532-7322

3.7 Security Compliance Review upon Request. Business Associate agrees to make its internal practices, books, and records, including policies and procedures relating to the security of electronic PHI received from, created by or received by Business Associate on behalf of Covered Entity, available to the Covered Entity or to the Secretary of the United States Department of Health in Human Services or the Secretary's designee, in a time and manner designated by the requester, for purposes of determining Covered Entity's or Business Associate's compliance with the Security Rule.

3.8 Cooperation in Security Compliance. Business Associate agrees to fully cooperate in good faith and to assist Covered Entity in complying with the requirements of the Security Rule.

4. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE

4.1 Use of PHI for Operations on Behalf of Covered Entity. Except as otherwise limited in this Agreement, Business Associate may use or disclose PHI to perform functions, activities, or services (i.e., treatment, payment or health care operations) for, or on behalf of, Covered Entity as specified in Service Agreements, provided that such use or disclosure would not violate the Privacy and Security Rule, if done by Covered Entity.

4.2 Other Uses of PHI. Except as otherwise limited in this Agreement, Business Associate may use PHI within its workforce as required for Business Associate's proper management and administration, not to include Marketing or Commercial Use, or to carry out the legal responsibilities of the Business Associate.

4.3 Third Party Disclosure Confidentiality. Except as otherwise limited in this Agreement, Business Associate may disclose PHI for the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or, if permitted by law, this Agreement, and the Service Agreement, provided that, if Business Associate discloses any PHI to a third party for such a purpose, Business

Associate shall enter into a written agreement with such third party requiring the third party to: (a) maintain the confidentiality, integrity, and availability of PHI and not to use or further disclose such information except as Required By Law or for the purpose for which it was disclosed, and (b) notify Business Associate of any instances in which it becomes aware in which the confidentiality, integrity, and/or availability of the PHI is breached within FORTY-EIGHT (48) HOURS or no more than TWO (2) BUSINESS DAYS of event.

4.4 Data Aggregation Services. Except as otherwise limited in this Agreement, Business Associate may use PHI to provide Data Aggregation Services to Covered Entity as permitted by 45 CFR § 164.504(e)(2)(I)(B).

4.5 Other Uses Strictly Limited. Nothing in this Agreement shall permit the Business Associate to share PHI with Business Associate's affiliates or contractors except for the purposes of the Service Agreement(s) between the Covered Entity and Business Associate(s) identified in the "LIST OF AGREEMENTS AFFECTED BY THIS [BUSINESS ASSOCIATE] AGREEMENT & HIPAA REQUIREMENTS" on page one of this Agreement.

4.6 Covered Entity Authorization for Additional Uses. Any use of PHI or other confidential TennCare information by Business Associate, its affiliate or Contractor, other than those purposes of this Agreement, shall require express written authorization by the Covered Entity, and a Business Associate agreement or amendment as necessary. Activities which are prohibited include, but not are not limited to, Marketing, as defined by 45 CFR § 164.503 or the sharing for Commercial Use or any purpose construed by Covered Entity as Marketing or Commercial use of TennCare enrollee personal or financial information with affiliates, even if such sharing would be permitted by federal or state laws.

4.7 Prohibition of Offshore Disclosure. Nothing in this Agreement shall permit the Business Associate to share, use or disclose PHI in any form via any medium with any third party beyond the boundaries and jurisdiction of the United States without express written authorization from the Covered Entity.

4.8 Data Use Agreement - Use and Disclosure of Limited Data Set. Business Associate may use and disclose a Limited Data Set that Business Associate creates for Research, public health activity, or Health Care Operations, provided that Business Associate complies with the obligations below. Business Associate may not make such use and disclosure of the Limited Data Set after any cancellation, termination, expiration, or other conclusion of this Agreement.

4.9 Limitation on Permitted Uses and Disclosures. Business Associate will limit the uses and disclosures it makes of the Limited Data Set to the following: Research, public health activity, or Health Care Operations, to the extent such activities are related to covered functions, including business planning and development such as conducting cost-management and planning-related analysis related to managing and operating Business Associates functions, formulary development and administration, development and improvement of methods of payment or coverage policies, customer service, including the provision of data analysis for policy holders, plan sponsors, or other customers, to the

extent such activities are related to covered functions, provided that PHI is not disclosed and disclosure is not prohibited pursuant to any other provisions in this Agreement related to Marketing or Commercial use.

5. OBLIGATIONS OF COVERED ENTITY

5.1 Notice of Privacy Practices. Covered Entity shall provide Business Associate with the notice of Privacy Practices produced by Covered Entity in accordance with 45 CFR § 164.520, as well as any changes to such notice.

5.2 Notice of Changes in Individual's Access or PHI. Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by an Individual to use or disclose PHI, if such changes affect Business Associate's permitted or required uses.

5.3 Notice of Restriction in Individual's Access or PHI. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use of PHI.

5.4 Reciprocity for Requests Received by Business Associate. The Parties agree that this Section (Section 5) is reciprocal to the extent Business Associate is notified or receives an inquiry from any individual within Covered Entity's covered population.

6. PERMISSIBLE REQUESTS BY COVERED ENTITY

6.1 Requests Permissible under HIPAA. Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy or Security Rule.

7. TERM AND TERMINATION

7.1 Term. This Agreement shall be effective as of the date on which it has been signed by both parties and shall terminate when all PHI which has been provided, regardless of form, by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if the Parties agree that it is unfeasible to return or destroy PHI, subsection 7.3.5 below shall apply.

7.2 Termination for Cause. This Agreement authorizes and Business Associate acknowledges and agrees Covered Entity shall have the right to immediately terminate this Agreement and Service Agreement in the event Business Associate fails to comply with, or violates a material provision of this Agreement and any provision of the Privacy and Security Rules.

7.2.1 Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:

- a) Provide notice of breach and an opportunity for Business Associate to reasonably and promptly cure the breach or end the violation, and terminate this BAA if Business Associate does not cure the breach or end the violation within the reasonable time specified by Covered Entity; or
- b) Immediately terminate this BAA if Business Associate has breached a material term of this BAA and cure is not possible; or
- c) If termination, cure, or end of violation is not feasible, Covered Entity shall report the violation to the Secretary.

7.3 Effect of Termination. Upon termination of this Agreement for any reason, except as provided in subsections 7.3.2 and 7.3.5 below, Business Associate shall at its own expense either return and/or destroy all PHI and other confidential information received, from Covered Entity or created or received by Business Associate on behalf of Covered Entity. This provision applies to all confidential information regardless of form, including but not limited to electronic or paper format. This provision shall also apply to PHI and other confidential information in the possession of sub-contractors or agents of Business Associate.

7.3.1 The Business Associate shall consult with the Covered Entity as necessary to assure an appropriate means of return and/or destruction and shall notify the Covered Entity in writing when such destruction is complete. If information is to be returned, the Parties shall document when all information has been received by the Covered Entity.

7.3.2 This provision (Section 7.3 and its subsections) shall not prohibit the retention of a single separate, archived file of the PHI and other confidential TennCare information by the Business Associate if the method of such archiving reasonably protects the continued privacy and security of such information and the Business Associate obtains written approval at such time from the Covered Entity. Otherwise, neither the Business Associate nor its subcontractors and agents shall retain copies of TennCare confidential information, including enrollee PHI, except as provided herein in subsection 7.3.5.

7.3.3 The Parties agree to anticipate the return and/or the destruction of PHI and other TennCare confidential information, and understand that removal of the confidential information from Business Associate's information system(s) and premises will be expected in almost all circumstances. The Business Associate shall notify the Covered Entity whether it intends to return and/or destroy the confidential with such additional detail as requested. In the event Business Associate determines that returning or destroying the PHI and other confidential information received by or created for the Covered Entity at the end or other termination of the Service Agreement is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction unfeasible.

7.3.4 Except for Business Associate Agreements in effect prior to April 21, 2005 when the Security Rule became effective, for the renewal or amendment of those same

Agreements, or for other unavoidable circumstances, the Parties contemplate that PHI and other confidential information of the Covered Entity shall not be merged or aggregated with data from sources unrelated to that Agreement, or Business Associate's other business data, including for purposes of data backup and disaster recovery, until the parties identify the means of return or destruction of the TennCare data or other confidential information of the Covered Entity at the conclusion of the Service Agreement, or otherwise make an express alternate agreement consistent with the provisions of Section 7.3 and its subsections.

7.3.5 Upon written mutual agreement of the Parties that return or destruction of PHI is unfeasible and upon express agreement as to the means of continued protection of the data, Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction unfeasible, for so long as Business Associate maintains such PHI.

8. MISCELLANEOUS

8.1 Regulatory Reference. A reference in this Agreement to a section in the Privacy and/or Security Rule means the section as in effect or as amended.

8.2 Amendment. The Parties agree to take such action to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy and Security Rules and the Health Insurance Portability and Accountability Act, Public Law 104-191. Business Associate and Covered Entity shall comply with any amendment to the Privacy and Security Rules, the Health Insurance Portability and Accountability Act, Public Law 104-191, and related regulations upon the effective date of such amendment, regardless of whether this Agreement has been formally amended.

8.3 Survival. The respective rights and obligations of Business Associate under Section 7.3 of this Agreement shall survive the termination of this Agreement.

8.4 Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity and the Business Associate to comply with the Privacy and Security Rules.

8.5 Headings. Paragraph Headings are used in this Agreement are for the convenience of the Parties and shall have no legal meaning in the interpretation of the Agreement.

8.6 Notices and Communications. All instructions, notices, consents, demands, or other communications required or contemplated by this Agreement shall be in writing and shall be delivered by hand, by facsimile transmission, by overnight courier service, or by first class mail, postage prepaid, addressed to the respective party at the appropriate facsimile number or address as set forth below, or to such other party, facsimile number, or address as may be hereafter specified by written notice. (For purposes of this section, effective notice to "Respective Party" is not dependent on whether the person named below remains employed by such Party.) The Parties agree to use their best efforts to immediately notify the other Party of changes in address, telephone number, fax numbers

and to promptly supplement this Agreement as necessary with corrected information.
Notifications relative to Sections 2.5, 3.4 and 3.5 of this Agreement must be reported to the Privacy Officer pursuant to Section 3.6.

COVERED ENTITY:

BUSINESS ASSOCIATE:

Darin Gordon	_____
Director	_____
Department of Finance and Adm.	_____
Bureau of TennCare	_____
310 Great Circle Road	_____
Nashville, TN 37243	_____
(615) 507-6443	_____
Fax: (615) 253-5607	Fax: _____

All instructions, notices, consents, demands, or other communications shall be considered effectively given as of the date of hand delivery; as of the date specified for overnight courier service delivery; as of three (3) business days after the date of mailing; or on the day the facsimile transmission is received mechanically by the facsimile machine at the receiving location and receipt is verbally confirmed by the sender.

8.7 **Strict Compliance.** No failure by any Party to insist upon strict compliance with any term or provision of this Agreement, to exercise any option, to enforce any right, or to seek any remedy upon any default of any other Party shall affect, or constitute a waiver of, any Party's right to insist upon such strict compliance, exercise that option, enforce that right, or seek that remedy with respect to that default or any prior, contemporaneous, or subsequent default. No custom or practice of the Parties at variance with any provision of this Agreement shall affect, or constitute a waiver of, any Party's right to demand strict compliance with all provisions of this Agreement.

8.8 **Severability.** With respect to any provision of this Agreement finally determined by a court of competent jurisdiction to be unenforceable, such court shall have jurisdiction to reform such provision so that it is enforceable to the maximum extent permitted by applicable law, and the Parties shall abide by such court's determination. In the event that any provision of this Agreement cannot be reformed, such provision shall be deemed to be severed from this Agreement, but every other provision of this Agreement shall remain in full force and effect.

8.9 **Governing Law.** This Agreement shall be governed by and construed in accordance with the laws of the State of Tennessee except to the extent that Tennessee law has been pre-empted by HIPAA and without giving effect to principles of conflicts of law. Jurisdiction shall be Davidson County, Nashville, Tennessee, for purposes of any litigation resulting from disagreements of the parties for purpose of this Agreement and the Service Agreement (s).

8.10 **Compensation.** There shall be no remuneration for performance under this Agreement except as specifically provided by, in, and through, existing administrative

requirements of Tennessee State government and Services Agreement(s) referenced herein.

IN WITNESS WHEREOF, the Parties execute this Agreement to be valid and enforceable from the last date set out below:

BUREAU OF TENNCARE

BUSINESS ASSOCIATE

By: _____

By: _____

Date: _____

Date: _____

Darin J. Gordon, Director

State of Tennessee, Dept of Finance & Adm.

310 Great Circle Road

Nashville, Tennessee

Phone: (615) 507-6443

Fax: (615) 253-5607

Phone: _____

Fax: _____



TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION
NO. 3 GROUP APPLICATION

www.state.tn.us/tenncare/Providers/enroll.html

(Check All That Apply) <input type="checkbox"/> New Enrollment <input type="checkbox"/> MCC Medicaid No. <input type="checkbox"/> Medicare/Medicaid No.		<input type="checkbox"/> Change of Ownership <input type="checkbox"/> Reactivation <input type="checkbox"/> Adding Practice/Satellite Location <input type="checkbox"/> Name Change and Tax ID # Change
Indicate Provider Type (Check One)		
<input type="checkbox"/> Clinic <input type="checkbox"/> Hospice <input type="checkbox"/> Hospital: <input type="checkbox"/> Acute <input type="checkbox"/> Critical Access <input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Group <input type="checkbox"/> Independent Lab <input type="checkbox"/> Ambulatory Surgical Ctr. <input type="checkbox"/> DME Supplier <input type="checkbox"/> Home Health Agency <input type="checkbox"/> Rural Health Clinic	<input type="checkbox"/> X-Ray Clinic <input type="checkbox"/> Nursing Homes: <input type="checkbox"/> ICF <input type="checkbox"/> SNF <input type="checkbox"/> ICF/MR <input type="checkbox"/> Other _____

Legal Business Name: _____

D/B/A: _____

Practice Location: _____
(No P.O. Box #)

City: _____ State: _____ Zip Code + 4: _____

Telephone: _____ Fax: _____ County: _____

If the name and address to which checks and remittance advices are to be sent is different from the name and address above, please provide that information below. This pay-to information should match the W-9 form.

Legal Business Name as reported to the IRS: _____

Street Address or P.O. Box: _____
(Pay-To Address)

City: _____ State: _____ Zip Code + 4: _____

Telephone No.: _____ Fax No.: _____

Federal Tax No. (IRS No.): _____ DEA No.: _____

Applying For: Part A _____ Part B _____

Medical Specialty: _____

Briefly describe the services you propose to offer to Medicaid recipients: _____

Medical supplies and durable medical equipment only — briefly describe the types of items and equipment you propose to supply to Medicaid recipients:

Federal Medicare No.: _____ State Medicaid No.: _____

NPI Number: _____

Taxonomy: _____, _____, _____, _____

Submit copies of professional and/or business licenses, accreditations, certifications, and registrations specifically required to operate as a health care provider.

Date of Issuance: _____ Expiration Date: _____

Have you or any other owner, managing director, etc., related to this application ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs? Yes ____ No ____. **If yes identify those person(s) by name and provide specifics for Medicaid evaluation. Attach this information to this application.**

Please list the full name of every owner, with Social Security number and percent of ownership (**required**). If owned by corporation, please list corporate officers with same information. Use additional paper if necessary.

Name	Title	SSN	% Ownership
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			

EFFECTIVE DATE FOR OPENING/REOPENING OFFICE: _____

EFFECTIVE DATE OF CHANGE OF OWNERSHIP: _____

If change of ownership, please provide the following:

Previous TN Medicaid Provider No. (if any): _____

Previous Name: _____

Street Address: _____

City: _____ State: _____ Zip Code + 4: _____

IF A CHANGE OF OWNERSHIP HAS OCCURRED, DO NOT BILL ANY CLAIM FOR DATES OF SERVICE ON OR AFTER THE DATE OF OWNERSHIP CHANGE UNTIL YOU ARE NOTIFIED THAT THIS APPLICATION HAS BEEN ACCEPTED AND ENROLLMENT HAS BEEN COMPLETED. FAILURE TO FOLLOW THIS PROCEDURE MAY RESULT IN RECOUPMENT OF CLAIMS PAID.

Application Surety Statement: "I certify that the information provided on this application is complete and correct to the best of my knowledge."

Signature: _____ Date: _____

(Original Signature of Administrator, Agent, or Owner)

Printed Name: _____ Title: _____

SUBSTITUTE W-9 FORM
REQUEST FOR TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION

1. Please complete general information:

Taxpayer Name: _____ Phone Number: _____

Business Name (if applicable): _____

Address: _____

City: _____ State: _____ ZIP Code: _____

2. Circle the most appropriate category below: (please circle only one)

- 1) Individual (not an actual business)
 - 2) Joint account (two or more individuals)
 - 3) Custodian account of a minor
 - 4)
 - a. Revocable savings trust (grantor is also trustee)
 - b. So-called trust account that is not a legal or valid trust under state law
 - 5) Sole proprietorship (using a social security number for the taxpayer ID)
 - 6) Sole proprietorship (using a federal employer identification number for the taxpayer ID)
 - 7) A valid trust, estate, or pension trust
 - 8) Corporation
 - 9) Association, club, religious, charitable, educational, or other non-profit organization
(for entities that are exempt from federal tax, use category 13 below)
 - 10) Partnership
 - 11) A broker or registered nominee
 - 12) Account with the U.S. Department of Agriculture in the name of a public entity that
receives agricultural program payments
 - 13) Government agencies and organizations that are tax-exempt under Internal Revenue
Service guidelines (i.e., IRC 501(c)3 entities)
-

3. Fill in your taxpayer identification number below: (please complete only one)

- 1) If you circled number 1-5 above, fill in your Social Security Number

__ __ __ - __ __ - __ __ __ __

- 2) If you circled number 6-13 above, fill in your Federal Employer Identification Number (EIN).

__ __ - __ __ __ __ __ __ __

Sign and date the form:

Certification – Under penalties of perjury, I certify that the number shown on this form is my correct taxpayer identification number. If I circled category 13 above, I also certify that my agency or organization is tax-exempt per Internal Revenue Service guidelines and not subject to backup withholding.

Signature: _____ Date: _____

Title (if applicable): _____

National Provider Identifier (NPI) Collection Form (Group Practices)

Any form not containing all required fields will be rejected.

Section 1 – Provider General Information

Business Name	<hr/>		
Doing Business As (Name)	<hr/>		
<hr/>	<hr/>	<hr/>	<hr/>
Medicaid ID	EIN	NPI	
Taxonomy Codes	<hr/>	<hr/>	<hr/>
	<hr/>	<hr/>	<hr/>

Section 2 – NPI Information

(Please Complete this Section for each Individual Provider that is associated with your Group. Please Make additional copies if required)

Provider Name	Medicaid ID	NPI	SSN	Taxonomy	Taxonomy

Section 3 – Primary Practice Location (As Entered on NPPES)

Address	<hr/>		
	<hr/>	<hr/>	<hr/>
	City	State	ZIP
<hr/>	<hr/>	<hr/>	
Phone Number	Fax Number	Provider Email Address	

Section 4 – Contact Information

Name of Individual Completing Form	<hr/>		
<hr/>	<hr/>	<hr/>	<hr/>
Phone Number	Fax Number	Contact Email Address	

Signature	Title
------------------	--------------

NPI Collection Form Surety Statement:
“I certify that the information provided on this application is complete and correct to the best of my knowledge.”

Instructions Group Practices

Send the completed NPI Collection Form via one of the following means:

Mail	Provider Enrollment Attn: NPI Collection 310 Great Circle Rd. Nashville, TN 37243 - 1700
Fax	(615) 741-0028
Field	Instruction
Section 1 – Provider General Information and NPI Information	
Provider Business Name	(Required) Enter the provider's name (Facilities, Agencies, Groups, Hospitals, etc.).
D/B/A Name	(Required If Applicable).
Medicaid ID No.	(Required) Enter the 7-digit Medicaid provider number.
EIN	(Required for a business entity) Enter the Employer Identification Number.
National Provider Identification Number	(Required) Enter the National Plan and Provider Enumeration System (NPDES) assigned NPI.
Section 2 – Group Member - NPI Information	
Provider Name	(Required) Enter the individual provider name linked to this group number.
Medicaid ID No.	(Required) Enter the 7-digit Medicaid provider number.
NPI Individual Provider Identifier	(Required) Enter the National Plan and Provider Enumeration System (NPDES) assigned NPI.
Social Security Number	(Required) Enter the Individual Provider SSN.
Taxonomy Codes	(Required) Enter the Taxonomy codes associated with the assigned NPI.
Section 3 – Primary Practice Location	
Address	(Required) Enter the primary practice location address of the provider as entered in the NPDES.
City	(Required) Enter the primary practice location City of the provider as entered in the NPDES.
State	(Required) Enter the primary practice location State of the provider as entered in the NPDES.
ZIP	(Required) Enter the primary practice location zip of the provider as entered in the NPDES. If known, include the ZIP +4.
Phone Number with area code	(Required) Enter the primary practice location phone number of the provider as entered in the NPDES.
Fax Number with area code	(Optional) Enter the primary practice location fax number of the provider as entered in the NPDES.
Provider Email Address	(Optional) Enter the primary practice location e-mail address of the provider as entered in the NPDES.
Section 4 – Contact Information	
Name of Individual Completing Form	(Required) Enter the name of the individual completing this form.
Phone Number with area code	(Required) Enter the phone number of the individual completing this form.
Fax Number with area code	(Optional) Enter the fax number of the individual completing this form.
Contact Email Address	(Optional) Enter the email address of the individual completing this form.
Signature/Title	Signature and Title of the person who has legally binding authority to provide information to the Bureau of TennCare with regards to the provider identified on the form.